Form 135
Rev. 7/99

SCHOOL BOARD OF MARTIN COUNTY
500 East Ocean Boulevard, Stuart, Florida 34994

PHYSICIAN'S AUTHORIZATION OF MEDICATION FOR A STUDENT AT SCHOOL

If at all possible, medication administration should be excluded during school hours by the utilization of a time-release or long-acting variety or simply alter the schedule to exclude school attendance hours. However, if it is necessary that medication be given during school hours in order to keep the student in optimum health and to help maintain school performance, please provide the following information:

Name of Student:_____ DOB:_____

School: _____ Date:_____

Medication: _____ Dosage:_____
Trade Name/Prescription Number — Amount/Times

Form of Medication: **Tablet** **Pill** **Capsule** **Inhalant** **Liquid**

NO INJECTIONS WILL BE GIVEN

Diagnosis/Symptoms	Possible Medication Side Effects

The parent/guardian knows of this request and is in full agreement that this medication will be supplied by the parent as needed. Should the student manifest any of the above-mentioned symptoms caused by the medication, please contact the parent/guardian or my office.

_____ _____
Physician's Signature — Date — Telephone Number

PARENT/GUARDIAN PERMISSION

I hereby give my permission for the above-mentioned student to receive medication during school hours.

_____ _____
Parent/Guardian Signature — Date — Telephone Number

FOR SCHOOL USE ONLY

Name and Title of Person to Administer Drug:_____

Approved By:_____ _____
Signature of Principal — Date

Reviewed By:_____ _____
Signature of Public Health Nurse — Date

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